MARICOPA COUNTY

COVERED DENTAL SERVICES
DELTA DENTAL OF ARIZONA
Premier Plan Network

Group #4500

Benefits Effective 07/01/08

ROUTINE SERVICES **100%**

DIAGNOSTIC:
Exams, evaluations or consultations (Twice in a benefit year)
X-rays: Full Mouth/Panorex or vertical bitewings (Once in a three-year period)
Bitewing (Twice in a benefit year)
Periapical
PREVENTIVE:
Routine Cleanings (limited to twice in a benefit year, or one difficult cleaning may be exchanged for one routine cleaning. However, the difficult cleaning is limited to not more than once in a five-year period.)
Topical Application of Fluoride (children through age 17 -Twice in a benefit year)
Sealants for Children (Once per three-year period for permanent molars & bicuspids up to age 19)
Space Maintainers (For missing posterior primary (baby) teeth)
EMERGENCY: (Palliative treatment)
Treatment for the relief of pain

BASIC SERVICES **80%**

RESTORATIVE:
Fillings consisting of silver amalgam; and, for front teeth only, synthetic tooth color fillings
Stainless Steel Crowns (For primary (baby) teeth only)
ORAL SURGERY:
Extractions
ENDODONTICS: Root Canal Treatment (Permanent Teeth); Pulpotomy (Primary (baby) Teeth)
PERIODONTICS:
Treatment of Gum Disease (Non-surgical-once every two years/Surgical once every three years)
Periodontal maintenance following periodontal treatment (limited to two cleanings per year in addition to routine cleanings)
BRIDGE AND DENTURE REPAIR:
Repair of such appliances to their original condition including relining of dentures.

MAJOR SERVICES **50%**

PROSTHODONTICS:
Bridges (Does not provide for lost, misplaced or stolen bridges or dentures.
Partial Dentures Five-year waiting period for replacement last performed)
Complete Dentures
RESTORATIVE: (Five-year waiting period for replacement last performed)
Cast Crowns - Jackets – Onlays – Inlays – synthetic posterior fillings - Implants

ORTHODONTIC SERVICES: **50%**

For adults & children age 8 and older. Benefits are limited to a maximum of **$3,000** per lifetime of the patient. This Orthodontic Maximum is separate from the Benefit Year Maximum.

BENEFIT YEAR BENEFIT MAXIMUM: **$2,000**

BENEFIT YEAR DEDUCTIBLE: $50.00 per Person; $100.00 per Family

Note: Deductible does not apply to Routine Services or Orthodontic Services
(**) Predetermination recommended for services over $250

Student Age – 19-25
www.deltadentalaz.com
BENEFITS SUBJECT TO ALL PROVISIONS, TERMS & CONDITIONS OF THE GROUP CONTRACT.